PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

Insurance Billing Form

Patient Information	
Name: Last First	DOB (MM/DD/YY): / /
Primary Insurance Information:	
Insurance Name:	
Member ID/ AHCCCS # / MEDICARE #:	**Group #:**
Subscriber/Insured Information	
(Please fill out as much information as possible, If subscriber is the patient, write in 'SELF',)	
Name: Last First	DOB (MM/DD/YY): / /
SS#: Phone #:	Relation to Patient:
Mailing Address:	City, State, Zip code:
Secondary Insurance Information:	
Insurance Name:	
Member ID/ AHCCCS # / MEDICARE #:	**Group #:**
Secondary Insurance- Subscriber/Insured Information	
(Please fill out as much information as possible, If subscriber is the patient, write in 'SELF',)	
Name: Last First	DOB (MM/DD/YY): / /
SS#: Phone #:	Relation to Patient:
Mailing Address:	City, State, Zip code:

These statements made by me or on my behalf are true and correct to the best of my knowledge. I hereby authorize CCPHSD to furnish information to my insurance carrier concerning my visit and I assign payments for medical services rendered to CCPHSD. I understand that I am financially responsible for all charges whether or not covered by my insurance plan.

Patient/Guardian Signature Date

Staff Comments: